



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <input checked="" type="checkbox"/> (Medicare#) <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Nirnoyy Nasidy						3. PATIENT'S BIRTH DATE MM DD YY 06 12 2017			SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)										
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)												
CITY			STATE			8. RESERVED FOR NUCC USE			CITY			STATE									
ZIP CODE			TELEPHONE (Include Area Code) ()									ZIP CODE			TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER												
a. OTHER INSURED'S POLICY OR GROUP NUMBER									a. INSURED'S DATE OF BIRTH MM DD YY M F												
b. RESERVED FOR NUCC USE									b. OTHER CLAIM ID (Designated by NUCC)												
c. RESERVED FOR NUCC USE									c. INSURANCE PLAN NAME OR PROGRAM NAME												
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED Signature on File DATE _____												SIGNED Signature on File									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 06 12 17 QUAL						15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE ENAYATI JOSEPH						17a. _____ 17b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO 0.00									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. R60.9		B. Z01.810		C. Z12.31		D. L		23. PRIOR AUTHORIZATION NUMBER													
E. L		F. L		G. L		H. L		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTER						25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> X						26. PATIENT'S ACCOUNT NO. 72050		27. ACCEPT ASSIGNMENT? (For govt claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 0.00		29. AMOUNT PAID \$ 0.00		30. Rsvd. for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION ASPC DOUGLAS 6911 N. BDI BLVD DOUGLAS, AZ 85607						33. BILLING PROVIDER INFO & PH # () SADDLEBACK PORTABLE X-RAY P.O. BOX 4427 SANTA ANA, CA 92701									
SIGNED 4403NPI DATE						a. 1083887186 b.															

SADDLEBACK PORTABLE X-RAY
PHONE: 714.835.2915
FAX: 714.543.3114

RADIOLOGY
ORDER REPORT

PATIENT'S NAME: Nirnoyy Nasidy	PATIENT'S ID: 32523	DATE OF BIRTH: 06-12-2017	SEX:	
ADDRESS:	CITY, STATE & ZIP: , ,		PHONE NO:	
ORDERING FACILITY: ASPC Douglas		ADDRESS: 6911 N. BDI Blvd		
CITY, STATE & ZIP: Douglas, AZ, 85607	PHONE NO: 46887654324		FAX: tyk	NPI:
REQUESTED DATE/TIME OF SERVICE: 06-12-2017, 23:40		TECHNOLOGIST: TECH FIVEs		
REFERRING DR'S NAME: ENAYATI JOSEPH	NPI:	PHONE NO:		FAX:

CPT CODE #1: 72050	PROCEDURE #1: Cervical, 4 views	
CPT CODE #2: 72070	PROCEDURE #2: Thoracic, 2 views	

SYMPTOMS:

MEDICARE #:	MEDICAID #:	INSURANCE CO. :	POLICY GROUP/FECA #:
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PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/_____

Saddleback Portable X-ray

Phone: 714.835.2915
Fax: 714.543.3114

Radiology ORDER REPORT

PATIENT NAME:	PATIENT ID#:	DATE OF BIRTH:	SEX:	
ADDRESS:	CITY, STATE & ZIP: ,			PHONE#:
ORDERING FACILITY:	ADDRESS:			
CITY, STATE & ZIP:	PHONE#:	FAX#:	NPI#:	
REQUESTED DATE/TIME OF SERVICE:				TECHNOLOGIST:
REFERRING DR'S NAME:	NPI#:	PHONE#:	FAX#:	

CPT CODE #1:	PROCEDURE #1:	
CPT CODE #2:	PROCEDURE #2:	

SYMPTOMS:

MEDICARE#:	MEDICAID#:	INSURANCE CO.:	POLICY/GROUP: /
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PHYSICIAN'S SIGNATURE: _____ Date: ____ / ____ / ____



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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)								
CITY			STATE		8. RESERVED FOR NUCC USE		CITY				STATE				
ZIP CODE		TELEPHONE (Include Area Code) ()					ZIP CODE				TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER								
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>								
b. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE					10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME								
d. INSURANCE PLAN NAME OR PROGRAM NAME							d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNED _____ DATE _____											SIGNED _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 					17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.											22. RESUBMISSION CODE ORIGINAL REF. NO.				
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.	23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS EPSDT Family Plan	H. I. ID. QUAL	J. RENDERING PROVIDER ID. #			
1											NPI				
2											NPI				
3											NPI				
4											NPI				
5											NPI				
6											NPI				
25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd. for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)											32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____											a. NPI	b.	a. NPI	b.	

Saddleback Portable X-Ray
Phone: 714.835.2915
Fax: 714.543.3114

Radiology
ORDER REPORT

PATIENT'S NAME: Alice Quitanilla	PATIENT'S ID: 12345	DATE OF BIRTH: 11-22-1991	SEX: Female
ADDRESS:	CITY, STATE & ZIP: , ,		PHONE NO: 9098169796
ORDERING FACILITY: ASPC Douglas		ADDRESS: 6911 N. BDI Blvd	
CITY, STATE & ZIP: Douglas, AZ, 85607	PHONE NO: 46887654324	FAX: tyk	NPI:
REQUESTED DATE/TIME OF SERVICE: 05-30-2017, 14:18		TECHNOLOGIST: TECH FIVEs	
REFERRING DR'S NAME: ENAYATI JOSEPH	NPI:	PHONE NO:	FAX:

CPT CODE #1: 72040	PROCEDURE #1: Cervical, 2 views	
CPT CODE #2: 72074	PROCEDURE #2: Thoracic, 4 views	

SYMPTOMS:

MEDICARE #:	MEDICAID #:	INSURANCE CO. :	POLICY GROUP/FECA #:
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PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/_____

Saddleback Portable X-Ray
Phone: 714.835.2915
Fax: 714.543.3114

Radiology
ORDER REPORT

PATIENT'S NAME: Alice Quitanilla	PATIENT'S ID: 12345	DATE OF BIRTH: 11-22-1991	SEX: Female
ADDRESS:	CITY, STATE & ZIP: , ,		PHONE NO: 9098169796
ORDERING FACILITY: ASPC Douglas		ADDRESS: 6911 N. BDI Blvd	
CITY, STATE & ZIP: Douglas, AZ, 85607	PHONE NO: 46887654324	FAX: tyk	NPI:
REQUESTED DATE/TIME OF SERVICE: 05-30-2017, 14:18		TECHNOLOGIST: TECH FIVEs	
REFERRING DR'S NAME: ENAYATI JOSEPH	NPI:	PHONE NO:	FAX:

CPT CODE #1: 72040	PROCEDURE #1: Cervical, 2 views	
CPT CODE #2: 72074	PROCEDURE #2: Thoracic, 4 views	

SYMPTOMS:

MEDICARE #:	MEDICAID #:	INSURANCE CO. :	POLICY GROUP/FECA #:
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PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/_____

Request for Taxpayer
Identification Number and CertificationGive Form to the
requester. Do not
send to the IRS.Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Tony Castillo.,CRT.

2 Business name/disregarded entity name, if different from above

Saddleback Portable X-Ray

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:

- Individual/sole proprietor or C Corporation S Corporation Partnership Trust/estate
 Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ► _____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
 Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
 Exempt payee code (if any) _____
 Exemption from FATCA reporting code (if any) _____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

1651 E. 4Th St. S#212 or P.O. Box 4427

Requester's name and address (optional)

6 City, state, and ZIP code

Santa Ana, CA. 92701

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			-			-			
--	--	--	---	--	--	---	--	--	--

or

Employer identification number

3	3	-	0	8	8	4	0	2	6
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Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign
HereSignature of
U.S. person ►

Tony Castillo.,CRT.

Date ► 04-04-17

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

- Form 1099-C (canceled debt)

- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.*

By signing the filled-out form, you:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

- Certify that you are not subject to backup withholding, or

- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

- Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Request for Taxpayer
Identification Number and CertificationGive Form to the
requester. Do not
send to the IRS.Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Tony Castillo.,CRT.

2 Business name/disregarded entity name, if different from above

Saddleback Portable X-Ray

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:

- Individual/sole proprietor or C Corporation S Corporation Partnership Trust/estate
 Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ► _____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
 Other (see instructions) ► _____

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
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1651 E. 4Th St. S#212 or P.O. Box 4427

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6 City, state, and ZIP code

Santa Ana, CA. 92701

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Social security number

			-			-			
--	--	--	---	--	--	---	--	--	--

or

Employer identification number

3	3	-	0	8	8	4	0	2	6
---	---	---	---	---	---	---	---	---	---

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- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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Sign
HereSignature of
U.S. person ►

Tony Castillo.,CRT.

Date ► 04-04-17

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- Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.